STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297150	A. BUILDING _____ B. WING _____	11/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME HEALTH AGENCY, INC	3120 SOUTH DURANGO DRIVE, SUITE 303 LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS Surveyor: 25418 This Statement of Deficiencies was generated as a result of the Medicare re-certification survey conducted at your agency from 11/16/09 through 11/18/09, in accordance with 42 CFR Part 484 - Home Health Services. The active census on the first day of the survey was 34. Eight clinical records were reviewed. Three employees were observed during two home visits. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	G 116		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 116	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interviews conducted during home visits, the agency failed to advise patients and/or families about the availability of the toll-free home health agency hotline telephone number for 1 of 2 patients visited. (Patient #3). Findings include: Patient #3 Patient #3 was admitted on 10/31/09 with diagnoses including oxygen dependent chronic obstructive pulmonary disease with exacerbation, non-insulin dependent diabetes mellitus and lumbago. On 11/18/09 in the morning, Patient #3 indicated when the nurse came out to do the admission paperwork, there was no mention of the toll free home health hotline number.	G 116		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on observation and interview, the agency failed to ensure employees observed professionally accepted standards of infection	G 121		

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G 121	Continued From page 2 control and bag technique for 1 of 2 patients visited by three employees. (Patient #3). Findings include: Patient #3 Patient #3 was admitted on 10/31/09 with diagnoses including oxygen dependent chronic obstructive pulmonary disease with exacerbation, non-insulin dependent diabetes mellitus and lumbago. On 11/18/09 during a home visit in the morning, the physical therapist (PT) placed the equipment bag on Patient #3's chair without a protective barrier underneath the bag. After using the equipment to obtain Patient #3's vital signs, the PT placed the equipment into the bag without first performing hand hygiene and cleaning the equipment. The PT moved the equipment bag from Patient #3's chair to the table and set the bag down without a protective barrier underneath it. After the PT left Patient #3's residence, the Registered Nurse (RN) arrived with a rolling bag which she left on the floor. During the RN's visit, the nurse put gloves on to perform/teach Patient #3 how to use the blood sugar testing control solutions for the patient's glucometer. After teaching Patient #3 how to use the control solutions, the RN kept the same gloves on. The RN reached into the nursing bag and retrieved a	G 121		

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G 121	Continued From page 3 stethoscope which she cleaned with an alcohol pad. With the same gloves still on, the RN reached into the bag for a pulse oximeter. The RN used the pulse oximeter on Patient #3 and then returned it to the bag without cleaning the equipment, and brought out an automatic blood pressure cuff. The RN took Patient #3's blood pressure on both arms and then returned the cuff to the bag without cleaning the equipment and while still wearing the same pair of gloves. When the RN was finished obtaining Patient #3's vital signs, the RN removed the gloves and placed them in a "dirty" zip lock bag. The RN did not perform hand hygiene after removing the gloves. After the visit with Patient #3, the RN was interviewed about the lack of hand hygiene between glove changes. She explained, "I don't want a lot of fluid buildup."	G 121		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interview and record review, the agency failed to ensure all personnel furnishing services	G 143		

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G 143	Continued From page 4 communicated with one another in an effort to effectively coordinate and support the objectives outlined in the plan of care for 4 of 8 patients (Patients #3, #4, #6, #8). Findings include: Patient #3 Patient #3 was admitted on 10/31/09 with diagnoses including oxygen dependent chronic obstructive pulmonary disease with exacerbation, non-insulin dependent diabetes mellitus and lumbago. Patient #3's clinical record lacked documented evidence the physical therapist and registered nurse communicated with each other regarding the patient's goals, issues, progress, etc. Patient #4 Patient #4 was admitted on 10/24/09 with diagnoses including emphysema, hypertension and congestive heart failure. Patient #4 was evaluated by physical therapy (PT) and determined to not need PT. The clinical record lacked documented evidence indicating PT notified skilled nursing regarding the PT status. Patient #4's clinical record lacked documented evidence the physical therapist and registered nurse communicated with each other regarding the patient's goals, issues, needs, progress, etc. during an initial case conference. Patient #6	G 143		

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G 143	Continued From page 5 Patient #6 was admitted on 6/5/09 with diagnoses including oxygen dependent respiratory abnormality, hypertension and heart failure. According to documentation in the clinical record, the physical therapist discharged Patient #6 on 7/3/09. The clinical record lacked documented evidence the physical therapist notified the RN regarding the discharge. Patient #8 Patient #8 was admitted on 3/11/09 with diagnoses including insulin dependent diabetes mellitus, hypertension and dementia with behavior disturbances. Patient #8's clinical record lacked documented evidence the physical therapist and registered nurse communicated with each other regarding the patient's goals, issues, needs, progress, etc.	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interview, record review and document review, the agency failed to ensure case conferences were held in order for the various disciplines to communicate with each other	G 144		

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G 144	Continued From page 6 regarding the concerns, issues and care needed for 3 of 8 patients (Patients #1, #2, #3). Findings include: Patient #1 Patient #1 was admitted on 7/23/09 with diagnoses including chronic obstructive pulmonary disease, Parkinson's disease, lumbago and hypertension. Patient #1 was seen by skilled nursing (SN) physical therapy (PT) and certified nursing assistant (CNA). A 9/15/09 "Initial Case Conference" had a signature by the SN. The form lacked documented evidence the PT and CNA participated in the case conference. Patient #2 Patient #2 was admitted on 11/7/09 with diagnoses including oxygen dependent emphysema, lumbago and abnormality of gait. An initial Case Conference dated 11/7/09 had no signatures affixed to it. In the area marked "Services Provided" none of the services was marked as having been selected. Patient #3 Patient #3 was admitted on 10/31/09 with diagnoses including oxygen dependent chronic obstructive pulmonary disease with exacerbation, non-insulin dependent diabetes mellitus and lumbago.	G 144		

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G 144	Continued From page 7 Patient #3's clinical record lacked documented evidence of an initial case conference. On 11/17/09 in the morning, the Director of Professional Services (DPS) indicated case conferences were completed at the time of the initial visit, after the patient had been on service for 30 days and again at recertification. The DPS explained, "All disciplines are supposed to call in with report and sign the document...the documents are maintained in a 3-ring binder...once it is signed by all assigned disciplines, it is placed in the patient's chart." The 3-ring binder contained several case conference forms without signatures. One of the initial case conference forms without signatures was dated 3/11/09. The 3-ring binder contained four case conference forms with all involved disciplines' signatures affixed. According to the agency's undated Case Conference/Progress Summary Policy No. HH:2-014.1, "Case conferences will be held at the start of care and at least every 60 days to review and discuss all multidisciplinary cases...1. Each multidisciplinary patient will have a case conference during the month following the certification month...4. A case conference/progress summary, written by the appropriate discipline(s) seeing the patient, will be placed in the patient's clinical record after each case conference meeting..."	G 144		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.	G 145		

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G 145	Continued From page 8	G 145		

This STANDARD is not met as evidenced by:
Surveyor: 25418
Based on record review, the agency failed to ensure the written 60 day summary sent to the physician met the regulatory definition (a compilation of the pertinent factors of a patient's clinical notes and progress notes) for 2 of 8 patients (Patients #1, #6).

Findings include:

Patient #1

Patient #1 was admitted on 7/23/09 with diagnoses including chronic obstructive pulmonary disease, Parkinson ' s disease, lumbago and hypertension.

During the first certification period, Patient #1 was seen by skilled nursing (SN), physical therapy (PT), occupational therapy (OT) for evaluation only, a social worker (SW) and certified nursing assistant (CNA).

The 60 day summary for the certification period of 9/21/09 through 11/19/09 lacked documented evidence regarding Patient #1 receiving the services of PT, OT, SW, CNA. There was no mention of the patient's status before and after the services, showing progress (or lack thereof) made.

Patient #6

Patient #6 was admitted on 6/5/09 with diagnoses including oxygen dependent respiratory abnormality, hypertension and congestive heart

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G 145	Continued From page 9 failure. The 60 day summary for the certification periods of 8/4/09 - 10/02/09 and 10/3/09 - 12/1/09 were virtually the same. There was no indication of how Patient #6 responded to physical therapy treatments, distances ambulated (initially and at the end of each period), what the blood pressure ranges actually were, what exactly the improvements in activities of daily living the patient experienced, and new medications as well as the patient's understanding/response.	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure care followed a written plan of care for 5 of 8 patients (Patients #2, #3, #6, #7, #8). Findings include: Patient #2 Patient #2 was admitted on 11/7/09 with diagnoses including oxygen dependent emphysema, lumbago and abnormality of gait. Patient #2's Plan of Care (POC) indicated the nurse was to call the patient's physician for a "temperature more than 101 degrees Fahrenheit."	G 158		

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G 158	Continued From page 10 On 11/17/09 during a home visit in the morning, the nurse did not check Patient #2's temperature. Patient #2's POC included orders for physical therapy (PT) and occupational therapy (OT) to evaluate and treat the patient. As of 11/17/09, the clinical record lacked documented evidence PT and OT had evaluated Patient #2. There were no physician's orders in the clinical record cancelling the PT and OT evaluations. Patient #3 Patient #3 was admitted on 10/31/09 with diagnoses including oxygen dependent chronic obstructive pulmonary disease with exacerbation, non-insulin dependent diabetes mellitus and lumbago. Patient #3's Plan of Care (POC) included orders for physical therapy (PT) "for gait training." Patient #3's evaluation documentation prepared by the PT did not include a frequency. There were no orders for PT frequency in the patient's clinical record. Documentation in Patient #3's clinical record revealed PT had seen the patient three times over three weeks. Patient #6 Patient #6 was admitted on 6/5/09 with diagnoses including oxygen dependent respiratory abnormality, hypertension and heart failure.	G 158		

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G 158	Continued From page 11 Patient #6's Plan of Care (POC) for the certification period of 10/3/09 - 12/1/09 indicated skilled nursing was to see the patient one time a week for nine weeks. Saturday, 10/3/09, was the last day of the first week of Patient #6's certification period. The clinical record lacked evidence of a SN visit note for that date. Patient #7 Patient #7 was admitted on 5/18/09 with diagnoses including atrial fibrillation, late effects status post cardiovascular accident and exacerbation of chronic obstructive pulmonary disease. Patient #7's Plan of Care for the certification period of 9/15/09 - 11/13/09 indicated skilled nurse was to see the patient two times a week for the first week, followed by one time a week for seven weeks. Patient #7's clinical record lacked documentation of a skilled nurse visit the third week and the sixth week of the certification period. Patient #8 Patient #8 was admitted on 3/11/09 with diagnoses including insulin dependent diabetes mellitus, hypertension and dementia with behavior disturbances. Patient #8's Plan of Care for the certification period of 9/7/09 through 11/5/09 indicated skilled nursing (SN) was to see the patient one time a week for nine weeks.	G 158		

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G 158	Continued From page 12 Patient #8's clinical record lacked documented evidence the SN saw the patient during the weeks of 10/4/09 and 11/1/09.	G 158		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to treatments were administered by staff only as ordered by the physician for 2 of 8 patients (Patient #3, #8). Findings include: Patient #3 Patient #3 was admitted on 10/31/09 with diagnoses including oxygen dependent chronic obstructive pulmonary disease with exacerbation, non-insulin dependent diabetes mellitus and lumbago. Patient #3's Plan of Care included orders for "PT for gait training." Patient #3's clinical record contained a physical therapy (PT) evaluation dated 11/4/09. The area marked "Frequency of Physical Therapy Visit" was left blank. There was no physician's order in the record indicating the frequency of visits for PT.	G 165		

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G 165	Continued From page 13 Patient 3's clinical record included documentation of two PT visits the week of 11/1/09 and one PT visit the week of 11/15/09. On 11/18/09 in the morning, during a home visit with the physical therapist, Patient #3 did not have the oxygen on initially. After participating in physical therapy, the patient experienced shortness of breath and oxygen at two liters per minute via nasal cannula was applied. Patient #3's clinical record included orders for "Oxygen 2 liters per minute via nasal cannula continuously." The clinical record did not have orders for the patient to wear oxygen on an "as needed" basis. Patient #8 Patient #8 was admitted on 3/11/09 with diagnoses including insulin dependent diabetes mellitus, hypertension and dementia with behavior disturbances. Patient #8's Plan of Care for the certification period of 9/7/09 - 11/5/09 included orders for skilled nursing (SN) to see the patient one time a week for nine weeks. Patient #8's clinical record included two SN notes for the week of 9/8/09.	G 165		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.	G 176		

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G 176	Continued From page 14 This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the registered nurse prepared complete clinical records for 3 of 8 patients (Patients #1, #4, #7). Findings include: Patient #1 Patient #1 was admitted on 7/23/09 with diagnoses including chronic obstructive pulmonary disease, Parkinson ' s disease, lumbago and hypertension. Patient #1's Plan of Care (POC) for the initial certification period of 7/23/09 - 9/20/09 which was prepared by the registered nurse (RN) included, "CNA (certified nursing assistant) to assist with personal grooming and ADL's (activities of daily living)." The POC lacked a frequency for the CNA to see the patient. A 7/29/09 physician's order written by the RN failed to indicate the effective date for the CNA to see Patient #1 two times a week for eight weeks. Patient #1's Plan of Care (POC) for the recertification period of 9/21/09 - 11/19/09 which was prepared by the registered nurse (RN) read, "Continue CNA/HHAIDE (Home Health Aide) services for assistance with personal grooming." There was no frequency indicated in the POC for the CNA to assist the patient with personal grooming.	G 176		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 15 Patient #4 Patient #4 was admitted on 10/24/09 with diagnoses including emphysema, hypertension and congestive heart failure. The goal established and documented in Patient #4's Plan of Care for the patient to be knowledgeable regarding medications was not measurable. Patient #4's clinical record included a Nursing Visit Record (NVR) dated 11/4/09. There was no signature and title on the note indicating who saw the patient on that date. Patient #7 Patient #7 was admitted on 5/18/09 with diagnoses including atrial fibrillation, late effects status post cardiovascular accident and exacerbation of chronic obstructive pulmonary disease. A 9/25/09 Nursing Visit Record (NVR) contained an incomplete entry by the registered nurse who saw Patient #7. The entry read, "... Educated PT (patient) regarding (--------blank)" A 9/30/09 NVR included documentation indicating Patient #7 had two wounds - one at the "L AC" (left antecubital) with serosanguinous drainage and one at the "L UA" (left upper arm) with serosanguinous drainage. The 9/30/09 NVR lacked documentation indicating the skilled nurse notified the physician of the changes to Patient #7's skin.	G 176		
G 185	484.32 THERAPY SERVICES	G 185		

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	297150	A. BUILDING _____ B. WING _____	11/18/2009

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G 185	Continued From page 16 Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and document review, the agency failed to ensure the physical therapy assistant was supervised by the qualified registered physical therapist for 1 of 8 patients (Patient #1). Findings include: Patient #1 Patient #1 was admitted on 7/23/09 with diagnoses including chronic obstructive pulmonary disease, Parkinson's disease, lumbago and hypertension. Patient #1 was seen by the physical therapy assistant (PTA) 13 consecutive times over a 5 week period without a supervisory visit from the registered physical therapist (RPT). A 9/1/09 PT visit note, signed by the RPT lacked documentation in the area set aside for supervision of the PTA. According to undated Policy No. HH:3-003.3, "...C... 1. Physical therapy assistants will be supervised by a physical therapist, ...at least every month unless state regulations require more frequent supervision...E. Supervisory visits	G 185		

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G 185	Continued From page 17 will be documented, dated, and signed by the supervising professional..."	G 185		
G 195	484.34 MEDICAL SOCIAL SERVICES If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the social worker prepared a complete plan of care for 1 of 8 patients (Patient #6). Findings include: Patient #6 Patient #6 was admitted on 6/5/09 with diagnoses including oxygen dependent respiratory abnormality, hypertension and heart failure. Patient #6's clinical record included a physician's order, dated 6/9/09 which read, "Evaluate and one prn (as needed)." The order did not specify the reason why the social worker might need to see Patient #6 after the initial evaluation.	G 195		
G 229	484.36(d)(2) SUPERVISION	G 229		

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G 229	Continued From page 18 The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and document review, the agency failed to ensure the registered nurse completed supervisory visits of the certified nursing assistant at least every 14 days for 2 of 8 patients (Patients #1, #8). Findings include: Patient #1 Patient #1 was admitted on 7/23/09 with diagnoses including chronic obstructive pulmonary disease, Parkinson's disease, lumbago and hypertension. Patient #1's clinical record included documentation indicating a certified nursing assistant (CNA) saw the patient two times a week for eight weeks during the initial certification period. Patient #1's clinical record lacked documented evidence indicating the registered nurse (RN) performed a CNA supervisory visit at least every 14 days during the initial certification period. During the second certification period, the CNA saw Patient #1 once a week for one week and twice a week for the remaining weeks.	G 229		

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G 229	Continued From page 19 Patient #1's clinical record lacked documented evidence the RN performed a CNA supervisory visit every 14 days throughout the entire second certification period. Patient #8 Patient #8 was admitted on 3/11/09 with diagnoses including insulin dependent diabetes mellitus, hypertension and dementia with behavior disturbances. Patient #8's clinical record included documented evidence of certified nursing assistant (CNA) visits two times a week from 9/7/09 through 11/5/09. Patient #8's clinical record lacked documented evidence the registered nurse performed a CNA supervisory visit every 14 days from 9/22/09 through 11/5/09.	G 229		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Surveyor: 25418	G 236		

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G 236	Continued From page 20 Based on record review, the agency failed to ensure complete records were maintained for 1 of 8 patients (Patient #7). Findings include: Patient #7 Patient #7 was admitted on 5/18/09 with diagnoses including atrial fibrillation, late effects status post cardiovascular accident and exacerbation of chronic obstructive pulmonary disease. Patient #7's clinical record lacked documented evidence of any medical history. There was no documented evidence of a request for the history from the referral source.	G 236		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on observation, interview, record review and document review, the agency failed to ensure updated medication profiles were maintained for 3 of 8 patients (Patients #2, #3, #7). Findings include:	G 337		

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G 337	Continued From page 21 Patient #2 Patient #2 was admitted on 11/7/09 with diagnoses including oxygen dependent emphysema, lumbago and abnormality of gait. On 11/17/09 in the morning during a visit to Patient #2's residence, the patient presented a prescription bottle with a label reading "Amitiza 24 mcg (micrograms) one tablet every day with food." The patient indicated he started it "three weeks ago." Patient #2 had a bottle of Lactulose and a container of Miralax, neither of which was listed on the Medication Profile. The patient indicated he had been taking them for "awhile." Patient #2's Medication Profile did not include Amitiza, Lactulose and Miralax. Patient #2's clinical record lacked documented evidence the patient was on these medications. During the same visit on 11/17/09, Patient #2's oxygen concentrator was observed to be set to deliver five liters per minute. The Plan of Care indicated the oxygen was to set at "2 - 3 liters per minute." Patient #3 Patient #3 was admitted on 10/31/09 with diagnoses including oxygen dependent chronic obstructive pulmonary disease with exacerbation, non-insulin dependent diabetes mellitus and lumbago. On 11/18/09 in the morning during a home visit, Patient #3 indicated she was taking Metformin	G 337		

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G 337	Continued From page 22 500 mg (milligrams) two tablets by mouth at 2:00 PM after lunch. Patient #3's Medication Profile (MP) revealed Metformin 500 mg one tablet by mouth twice daily was ordered initially. An 11/11/09 nursing visit record prepared by a registered nurse revealed Patient #3 was taking Metformin 1,000 mg one tablet po (by mouth) bid (twice a day). During the home visit on 11/18/09, Patient #3 indicated she was taking Glyburide 5 mg four tablets po every day and Lisinopril 40 mg one tablet po every day (as of 11/10/09). The MP lacked documentation of Patient #3 being prescribed Glyburide and Lisinopril. Patient #3 was not using oxygen when the registered nurse and surveyor arrived. The patient indicated she "only used it as needed during the daytime and all night long." According to the Plan of Care (POC) and MP, Patient #3 was to use the oxygen "continuously." Patient #7 Patient #7 was admitted on 5/18/09 with diagnoses including atrial fibrillation, late effects status post cardiovascular accident and exacerbation of chronic obstructive pulmonary disease. A 9/25/09 Nursing Visit Record included documentation of Patient #7 taking "Tylenol 500 mg one tab by mouth every 6 hours."	G 337		

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G 337	Continued From page 23 Patient #7's Medication Profile prepared on 9/14/09 lacked an entry for Tylenol. The clinical record lacked a physician's order for Tylenol. According to the agency's undated Medication Profile Policy No. HH:2-028.1, "...Medication profiles will be updated for each change to reflect current medications, new, and/or discontinued medications....2. A drug regimen review will be performed ... and with the addition of a new medication..."	G 337		